Health Care Provider Complaint Form

This information MUST be completed to investigate your complaint, as we correspond via U.S. mail. Incomplete forms CANNOT be processed.

Florida Statutes 456.073, Disciplinary proceeding: (1) The department, for the boards under its jurisdiction, shall cause to be investigated any complaint that is filed before it if the complaint is in writing, signed by the complainant, and legally sufficient. *If an investigation of any subject is undertaken, the Department will furnish to the subject or the subject's attorney a copy of the complaint or document that resulted in the initiation of the investigation.*

Health Care Provider Information:

Name: Lee County Sheriff's Office (Last) Jail and medical services provider (First) ____ (M.I.) ____ (Profession) ____ (License Number)

Address: 14750 6 Mile Cypress Pkwy (Number & Street) fort myers (City) fl (State) 33912 (Zip)

Phone number(s): (239) 477-1000 Website: https://www.sheriffleefl.org/

Complainant Information:

Agency/Company Name (if applicable): U.S. Justice Coalition

Your Name: huminski (Last) scott (First) a (M.I.)

Address: 24544 kingfish street (Number & Street) bonita springs (City) fl (State) 34134 (Zip)

Phone Number: 239 300 6656 Email: ____

Patient Information:

Please complete this section if you are filing a complaint on behalf of the patient. If you are the patient, please leave this section blank.

Name: ____ (Last) (First) (M.I.)

Address: ____ (Number & Street) (City) (State) (Zip)

Phone Number: ____ Date of Birth: ____

Your relationship to the patient:

☑ Self ☐ Parent ☐ Son/Daughter ☐ Spouse ☐ Brother/Sister ☐ Legal Guardian ☐ Other: ____

Please provide documentation indicating your appointment as the legal authority/guardianship or personal representative.

The Department does not investigate complaints regarding the amount charged for a procedure, broken or missed appointments, customer service, bedside manner, rudeness, professionalism or personality conflicts.

If the incident involved criminal conduct, contact local law enforcement. Have you contacted local law enforcement?

☑Yes ☑No

If Yes, Name of Contact: _____ Date: _____ Case Number: _____

Agency Name:_____

Provide a complete description of the complaint/report.
Include facts, details, dates, locations, etc. (who, what, when and where)
Attach additional sheets if necessary.

Please make and attach copies of medical records, correspondence, contracts and any other documents that will help support your complaint. Failure to attach records will delay the investigation.

Date of Incident: February-March 2019

See attached affidavit signed under oath

The complaint form must be signed and returned to the Department.

Signature: _____ Date: 10/7/2019

(Required to file complaint)

You may scan and return the form via email to:

MQA.consumerservices@flhealth.gov

You may mail the form to:

Consumer Services Unit
4052 Bald Cypress Way, Bin C-75
Tallahassee, FL 32399-3275

You may fax the form to:

850-488-0796

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Health Care Provider Information:

Name: Unkown doctors and pharmacists working at Lee County Sheriff's Office Doctors and Pharmacists
(Last / First / M.I. / Profession / License Number)

Address: 14750 Six Mile Cypress Hwy fort myers fl 33912
(Number & Street / City / State / Zip)

Phone number(s): 239 477 1000 Website: sheriffleefl.org

Complainant Information:

Agency/Company Name (if applicable): U.S. Justice Coalition

Your Name: huminski scott a
(Last / First / M.I.)

Address: 24544 Kingfish Stret Bonita Springs fl 34134
(Number & Street / City / State / Zip)

Phone Number: 239 200 6656 Email: s_huminski@live.com

Patient Information:

Please complete this section if you are filing a complaint on behalf of the patient. If you are the patient, please leave this section blank.

Name: _____
(Last / First / M.I.)

Address: _____
(Number & Street / City / State / Zip)

Phone Number: _____ Date of Birth: _____

Your relationship to the patient:

☑ Self ☐ Parent ☐ Son/Daughter ☐ Spouse ☐ Brother/Sister ☐ Legal Guardian ☐ Other: _____

Please provide documentation indicating your appointment as the legal authority/guardianship or personal representative.

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If the incident involved criminal conduct, contact local law enforcement. Have you contacted local law enforcement?

☐ Yes ☑ No

If Yes, Name of Contact: _____ Date: _____ Case Number: _____

Agency Name: _____

Provide a complete description of the complaint/report.
Include facts, details, dates, locations, etc. (who, what, when and where)
Attach additional sheets if necessary.

Please make and attach copies of medical records, correspondence, contracts and any other documents that will help support your complaint. Failure to attach records will delay the investigation.

Date of Incident: february-march 2019

see attached sworn complaint/affidavit

The complaint form must be signed and returned to the Department.

Signature: _____ Date: 10/7/2019

(Required to file complaint)

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You may fax the form to:

850-488-0796

Florida HEALTH
Medical Quality Assurance

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

To: Any and All Treating Health Care Practitioners or Facilities:
This authorization meets the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy Law) found at 45 CFR, Part 164.

This document authorizes any and all licensed health care practitioners, including but not limited to: physicians, nurses, therapists, social workers, counselors, dentists, chiropractors, podiatrists, optometrists, hospitals, clinics, laboratories, medical attendants and other persons who have participated in providing any health care or service to me, to discuss any communication, whether confidential or privileged, and to provide full and complete patient reports and records justifying the course of treatment including but not limited to: patient histories, x-rays, examination and test results, HIV, mental health, drug abuse treatment, psychiatric and psychological records, reports or information prepared by other persons that may be in your possession and all financial records, to the Department of Health (or any official representative of the Department) pursuant to Section 456.057, Florida Statutes.
This document provides full authorization to the Department of Health (or any official representative of the Department) to use any of the aforementioned reports and information for reproduction, investigation or other use for licensure or disciplinary actions and civil, criminal or administrative proceedings, as needed by the Department and may be subject to re-disclosure by the recipient and may no longer be protected by the federal privacy laws and regulation.
By signing below, the patient understands, acknowledges and authorizes the Department to release their identity and medical records to law enforcement and other regulatory agencies in appropriate circumstances at the Department's discretion.

A photocopy of this document is as sufficient as the original.

I understand that this authorization may be revoked upon my written request except to the extent that action has already been taken on this authorization.

Patient Name (Print): scott huminski Signature: _____

D.O.B.: 12-1-59 SSN: 045-40-4327 Date: 10/7/2019

Name of Authorized Person Other than Patient (Print): none

Signature of Authorized Person Other than Patient: none

Witness Name (Print): _____ Witness Signature: _____

DOH USE ONLY
Reference Number

_____

In The

Florida Board of Medicine / Florida Board of Pharmacy

Lee County, SS.

SCOTT HUMINSKI, COMPLAINANT	)
	)
Respondents,	)
MEDICAL PROVIDER/EMPLOYER,	)
LEE COUNTY SHERIFF'S OFFICE	)
JANE/JOHN DOES, M.D.	)

Complaint / Affidavit of Scott Huminski

NOW COMES, Scott Huminski ("Huminski"), and, under oath, hereby states, swears, complains and deposes as follows,

1) Twenty two years ago Huminski was prescribed Toprol ER for blood pressure and alprazolam for anxiety. Huminski has been on these medications to the present except when he was under the medical care of the Lee County Sheriff's Office ("LCSO") and their medical staff.
2) Prior to being placed on Toprol ER, Huminski tried diuretics and had severe side effects including Red Man Syndrome.
3) Huminski was arrested and lodged at the LCSO jails for 20 days in February and March of 2019 for failing to pay a fine for contempt of court.

4) Upon arrest, Huminski was brought to jail and immediately put in solitary confinement without regard for his medical needs. After 8 hours in solitary, Huminski was interviewed by LCSO staff and Huminski supplied a list of his medications including alprazolam, Toprol ER and Lovaza..

5) LCSO chose to discontinue Huminski's medications without notifying him, without consent and without an interview/consultation by a physician.

6) Huminski had no contact with a Doctor until 5-7 days into his lodging with the LCSO, yet, all his medications were changed without seeing a doctor and without an inquiry into Huminski's medical history.

7) In the past Huminski had tried to substitute Metoprolol Succinate (Toprol ER), with Metoprolol Tartrate (Lopressor), a much more affordable medicine. Huminski found the Lopressor not effective and his private doctor advised the long-acting Toprol ER was superior.

8) Throughout his care under the LCSO and their Medical Doctor, Huminski's blood pressure soared for weeks until he finally was supplied Toprol ER. Huminski gets anxiety symptoms and an uncomfortable feeling in his chest when his blood pressure soars, which is what happened with the LCSO handling his health care.

9) For the first week of lodging with the LCSO, Huminski was given medications in a small dixie cup which Huminski presumed included medications he had been taking for the last 22 years and he was not

informed that his medications had been stopped and/or modified without his consent or knowledge.

10) Along with soaring blood pressure, Huminski began experiencing symptoms of Red Man Syndrome over his entire body and eventually all his skin peeled off in a manner similar to sunburn.

11) Huminski, suspecting he was given medications that were ineffective or outright toxic to him, began to ask the nurse what the medications were and as it turns out he was told one medication was a "water pill" which Huminski still does not know the specific medication although he knows not to take this family of medicines from past experience and, similarly Huminski knew he had to take Toprol ER not Lopressor for his high blood pressure. Because of a refusal of the medical staff to inform patients of medication changes, potentially deadly results may occur at LCSO facilities.

12) Huminski began refusing the medication that had proven toxic to him in the past, but, knowing of this toxicity, the LCSO kept trying to dispense to him doses of the toxin.

13) Huminski believes the secrecy of the LCSO medical staff in not advising him that his medications were being withheld and that he was getting new medicines caused his soaring blood pressures and Red Man Syndrome. If a new medication plan was suggested to Huminski, he would have advised his physician of the problems with the new medications that he knew from past experiences.

14) When Huminski saw a female physician at 5-7 days at the LCSO facility, he was prescribed a corticosteroid to relieve his Red Man symptoms although the diuretics were still provided to him which he had to continue to refuse. This is after he told the physician of his history with these medications.

15) Huminski believes no prescribing changes should be made without a doctor's consultation and a medical history taken to avoid side effects or allergies with medicines secretly provided to individuals. Even consultation by telephone with a physician would have eliminated these medical errors and provided the necessary medical history.

16) Huminski does not know the identity of the doctor(s) involved in his medical situation with the LCSO and his direct oral request for his records from the LCSO M.D. was refused.

17) On 9/24/19 Huminski attempted to get his medical records from the LCSO by visiting two LCSO locations without success.

18) Huminski has filed a freedom of information request to the LCSO to obtain his medical records and he is awaiting a response. See link, https://www.muckrock.com/foi/lee-county-36/lee-sheriff-records-request-81140/

19) Both the pharmacists and doctors involved with the LCSO know that new residents with LCSO do not get any consultation with a M.D. prior to initial prescribing of medicines or discontinuing medicines.

20) Although Huminski may or may not have had symptoms related to the sudden stopping of alprazolam, its clear from just looking at the

prescribing information that this is not a safe practice. It also is not safe to experiment with a patient's blood pressure medication without first seeing the patient.

21) The LCSO physicians and pharmacist employees failed to "Do No Harm", by design of the system they work within.

22) Huminski waives all HIPAA rights related to his medical records held by the LCSO and these records may be made public to further transparency related to this rogue medical provider.

Dated at Bonita Springs, Florida this 7th day of October, 2019.

Scott Huminski
24544 Kingfish Street
Bonita Springs, FL 34134
(239) 300-6656
S_huminski@live.com

SWORN AND SUBSCRIBED to before me on October 7, 2019

NOTARY EXP Nov. 15, 2020

HARMONY J. MULLINS
Notary Public - State of Florida
Commission # GG 047913
My Comm. Expires Nov 15, 2020